



NW DERMATOLOGY  
INSTITUTE

**Cancellation and “No-Show” Policy**

Our goal is to help clients, patients, and the community receive quality dermatological and aesthetic care. Late cancellations and “no-shows” inconvenience those individuals who need access to treatment and services. In order to be respectful of the needs of other clients and patients, we request that you call NW Dermatology promptly if you are unable to attend an appointment. Appointments are in high demand and your early cancellation will give another person the possibility to have access to exceptional care and services in a timely manner.

**If it is necessary to cancel your scheduled dermatology appointment, we require that you call at least 1 *business* day in advance.**

**If it is necessary to cancel your scheduled appointment with a certified advanced esthetician/laser technician, we require that you call at least 2 *business* days in advance.**

**If it is necessary to cancel your scheduled new patient appointment associated with hair loss, we require that you call at least 3 *business* days in advance.**

**If this policy is not followed, a \$75.00 cancellation or “no-show” fee will be incurred.** Please note that the fee will be waived for cases of illness, emergencies, or when we are able to reschedule the appointment for the same day as the cancellation.

A late cancellation is an appointment that is cancelled within the 1, 2, or 3 business day(s) prior to the scheduled appointment (as outlined above). A “no-show” is an appointment a patient does not attend due to failure of notifying our office of the cancellation or need to reschedule.

To cancel your appointment, please call our office at 503.223.1933. If you are unable to reach a front office coordinator you may leave a detailed message with your name, date of birth, and phone number on our secure voicemail. If you would like to reschedule, we will return your call and provide you with upcoming available appointment times.

**Thank you for your cooperation in helping us to provide the best possible care for you and for the community.**

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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